

**MEDICAID ADMINISTRATIVE CLAIMING PROGRAM
STATE OF WASHINGTON - LOCAL HEALTH JURISDICTIONS
QUESTIONNAIRE FOR SKILLED PROFESSIONAL MEDICAL PERSONNEL
FOR USE BY SOCIAL WORKERS AND OTHER ALLIED HEALTH PROFESSIONALS**

Name _____ Job Title _____
Agency _____ Program _____
County _____ Claiming Unit _____

The following information will be used to document the professional education and training in the field of medical care or appropriate medical practice, a requirement for Skilled Professional Medical Personnel (SPMP) under the Medicaid Administrative Claiming program. This form should be completed by employees with a background in social work, psychology, counseling and other allied health professionals (such as MPHs). Please respond to all of the questions. Thank you.

1. THIS QUESTION IS TO BE COMPLETED BY SOCIAL WORKERS ONLY

(a.) Have you completed a master's degree in social work from an accredited two-year graduate program? ___ YES ___ NO

If YES, please answer items (b-e) below. If NO, please stop, sign the form and turn it in to your supervisor.

(b.) Please list the academic degree and the name of the college/university where it was received.

Academic Degree _____

College or University _____

(c.) As part of your MSW degree program, did you complete a concentration, specialization or track, in clinical practice, health care practice, or other medical application?
___ YES ___ NO Other concentration? ___ YES ___ NO

Please list the concentration, specialization or track. _____

(d.) If you did not complete a concentration in clinical or health care practice or other medical application, did you take any courses that had medical or health-related focus (for example, about health, mental health, substance abuse or medical social work)? (NOTE: This does not include continuing education courses or credits.) ___ YES ___ NO

If YES, please list these courses (including credit hours) below. If more space is needed, please use the back of this form.

Course Name	Credit Hours
_____	_____
_____	_____
_____	_____

If you answered NO to Item 1(d) above, please stop, sign this form and turn it in to your supervisor.

(e.) Did part of your two-year or longer MSW program involve medical or health-related training, including field work or internships (for example, in the area of health, mental health or substance abuse)? (Note: This refers to a practicum or field placement linked to your MSW program, and does not include work experience or on-the-job training. It may include a medical or clinical field experience in a non-medical setting, such as a school or prison.) ____
YES ____ NO

If YES, please describe each applicable fieldwork or internship (including credit hours), note the setting in which it occurred and your responsibilities or experiences.

Type of Fieldwork/Internship _____ Credit
Hours _____

Setting (Agency) _____

Responsibilities/Experiences _____

Type of Fieldwork/Internship _____ Credit
Hours _____

Setting (Agency) _____

Responsibilities/Experiences _____

Please proceed to Question 3.

2. THIS QUESTION IS TO BE COMPLETED BY ALL OTHER ALLIED HEALTH PROFESSIONALS (EXCEPT MSWs)

(a.) Have you completed an accredited professional educational program in a health or health-related field at a college or university that lasted at least two years? (Examples are clinical psychology, marriage and family therapy, or masters of public health.)
____ YES ____ NO

If YES, please list the highest academic degree you received in a health or health-related field, the subject in which it was received, and the name of the college/university where it was received.

Academic Degree _____ Field/Subject Area

College or University _____

If you answered NO to this question, please stop, sign this form and turn it in to your supervisor. Otherwise, please proceed to item (b.)

(b.) As a part of your two-year or longer educational program, did you take any courses that had a medical or health-related focus (for example, about health, mental health, or substance abuse)? (NOTE: This does not include continuing education courses or credits.) ____ YES

___ **NO**

If YES, please list these courses (including credit hours) below. If more space is needed, please use the back of this form.

Course Name	Credit Hours
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(c.) Did part of your two-year or longer educational program involve medical or health-related training, including field work or internships (for example, in the area of health, mental health or substance abuse)? (Note: This refers to a practicum or field placement linked to an educational program, and does not include work experience or on-the-job training. It may include a medical or clinical field experience in a non-medical setting, such as a school or prison.) ___ **YES** ___ **NO**

If YES, please describe each applicable fieldwork or internship (including credit hours), note the setting in which it occurred and your responsibilities or experiences.

Type of Fieldwork/Internship _____ Credit Hours _____

Setting (Agency) _____

Responsibilities/Experiences _____

Type of Fieldwork/Internship _____ Credit Hours _____

Setting (Agency) _____

Responsibilities/Experiences _____

Please proceed to Question 3.

- 3. Did your educational program lead to licensure by a National or State medical licensure organization? (An example is State licensure as a psychologist or clinical social worker.)**
___ **YES** ___ **NO**

If YES, please provide license type, number, valid dates, and licensure organization, then sign this form and turn it in to your supervisor.

License Type _____ License Number _____

Valid Dates _____

Licensure Organization _____

If you answered NO to Item 3 above, please proceed to Question 4.

4. Did your educational program lead to certification or registration by a medical or health-related National or State certifying organization? ☐ YES ☐ NO

If YES, please provide certification/registration type and number, valid dates, and the name of the certifying organization.

Certificate/Registration Type _____

Certificate/Registration Number _____ Valid Dates _____

Certifying/Registry Organization _____

Please sign this form and turn it in to your supervisor.

Employee Signature

Date